

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PURPOSE OF AUTHORIZATION

A federal statute protects you from unauthorized use or disclosure of your individually identifiable health information. That statute is called the Health Insurance Portability and Accountability Act (HIPAA).

Missouri Western State University recognizes that you may desire the assistance of the campus Human Resources Department with respect to claim issues in the Blue Cross Blue Shield of Kansas City Health Plan (the Plan). HIPAA requires an authorization in order for your campus Human Resources Department to discuss or assist with the claim or other communication regarding benefits involving individually identifiable health information.

Important Note: You may refuse to sign this Authorization. If you refuse to sign the Authorization, the Member/Campus Human Resources Department will not be able to discuss the claims or other communication regarding benefits involving individually identifiable health information with you or Blue Cross Blue Shield of Kansas City.

INFORMATION ABOUT THE USE OR DISCLOSURE

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entities providing the information.* **CHECK THE APPLICABLE OPTIONS BELOW.**

Patient Name: _____ Social Security or Blue Cross Blue Shield ID Number: _____

A. Persons/organizations authorized to provide the information:

____ Blue Cross Blue Shield of Kansas City

____ Member/Campus Human Resources Department: Sandi Berg/Jan Aspelund

B. Persons/organizations authorized to receive the information:

Blue Cross Blue Shield of Kansas City

Member/Campus Human Resources Department: Sandi Berg/Jan Aspelund

C Specific description of information to be used or disclosed (including date(s)):

All health information related to the claims; or

Specific information: _____

D. Specific purpose of the disclosure:

To allow the Member/Campus Human Resources Department to discuss the following identified claims with Blue Cross Blue Shield of Kansas City office and me; or

Patient Name	Claim Number	Provider	Date of Service

E. Will the Health Plan or Health Plan provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No Yes _____ (describe) _____

F. This authorization will expire upon:

_____ Resolution of the above referenced claims, but in no event later than _____,
2005 (can't be later than December 31, 2005).

Important Information About Your Rights

I have read and understood the following statements about my rights:

- * I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation. (A place is indicated at the end of this document to revoke this authorization).
- * I may see and copy the information described on this form if I ask for it.
- * I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- * The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

Signature of Patient or Patient's Representative

Signature of patient or patient's representative
(Form *MUST* be completed before signing)

Date

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative: _____

PLEASE PROVIDE COPY OF DOCUMENT DESIGNATING REPRESENTATIVE STATUS (if not parent/child relationship)

Revocation of Authorization

I hereby revoke the above Authorization:

Signature of patient or patient's representative

Date